AMENDED IN ASSEMBLY JUNE 30, 2016

AMENDED IN ASSEMBLY JULY 16, 2015

AMENDED IN SENATE MAY 5, 2015

AMENDED IN SENATE APRIL 20, 2015

SENATE BILL No. 503

Introduced by Senator Hernandez

February 26, 2015

An act to amend ~~Sections 1366.22 and 24100 of, and to amend, repeal, and add Sections 1366.24 and 1366.25 of, the Health and Safety Code, and to amend Section 10128.52 of, and to amend, repeal, and add Sections 10128.54 and 10128.55 of, the Insurance Code, relating to health care coverage.~~ *Section 1418.8 of the Health and Safety Code, relating to health facilities.*

LEGISLATIVE COUNSEL'S DIGEST

SB 503, as amended, Hernandez. ~~Cal-COBRA: disclosures.~~ *Long-term health facilities: informed consent.*

Existing law requires the attending physician of a resident in a skilled nursing facility or intermediate care facility that prescribes or orders a medical intervention of a resident that requires the informed consent of a patient who lacks the capacity to provide that consent, as specified, to inform the skilled nursing facility or intermediate care facility. Existing law requires the facility to conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention, subject to specified proceedings. Existing law authorizes a medical intervention prior to the facility convening an interdisciplinary team review in the case of an emergency, under specified circumstances. Existing law requires the team to meet within

one week of the emergency for an evaluation of the medical intervention if the emergency results in the application of physical or chemical restraints. Existing law imposes civil penalties for a violation of these provisions.

This bill would expand the above-described process, as specified, and would impose additional duties on a physician who prescribes a medical intervention under these provisions and on skilled nursing facilities and intermediate care facilities, as defined, under these provisions. Among other things, the bill would require a physician who prescribes a medical intervention to document certain information in the medical record of the resident. The bill would require a skilled nursing facility or intermediate care facility to notify the resident of a determination of a physician pursuant to the above within 48 hours of his or her determination, as prescribed. The bill would authorize a patient or representative of the patient, as described, to take certain action in response to a medical intervention. Under circumstances in which an emergency results in the application of physical or chemical restraints, or the administration of antipsychotic medications, the bill would require the interdisciplinary team to meet for an evaluation of the emergency intervention. The bill would impose additional requirements on the administration of antipsychotic medications by a facility, as prescribed, which would include, among other things, an independent medical review of the appropriateness of the proposed medical intervention.

~~The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. The California Continuation Benefits Replacement Act (Cal-COBRA) requires health care service plans and health insurers providing coverage under a group benefit plan to employers of 2 to 19 eligible employees to offer a continuation of that coverage for a specified period of time to certain qualified beneficiaries, as specified. Existing law requires a group benefit plan that is subject to Cal-COBRA to make specified disclosures to covered employees, including that a covered employee who is considering declining continuation of coverage should be aware that companies selling individual health insurance may require a review of the employee's medical history that could result in a higher premium or denial of coverage.~~

~~This bill would eliminate the disclosure requirement described above. If federal law requiring an individual to maintain minimum health coverage is repealed or amended to no longer apply to the individual market, as specified, the bill would reenact that disclosure requirement to become operative 12 months after that repeal or amendment. The bill would also, under those same conditions, require a contract between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to make the same disclosure to a qualified beneficiary in connection with a notice regarding election of continuation coverage. The bill would require a group benefit plan that is subject to Cal-COBRA and that issues, amends, or renews a disclosure on or after July 1, 2016, to include a notice regarding additional health care coverage options in that disclosure, as specified. The bill would require a group contract that is issued, amended, or renewed on or after July 1, 2016, between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to give that notice regarding additional health care coverage options to a qualified beneficiary of the contract in connection with a notice regarding election of continuation coverage. The bill would make conforming changes to related provisions.~~

~~Because a willful violation of the bill's requirements relative to health care service plans would be a crime, this bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

SECTION 1. Section 1418.8 of the Health and Safety Code is amended to read:

1418.8. (a) *(1)* If the attending physician ~~and surgeon~~ of a resident in a skilled nursing facility or intermediate care ~~facility~~ *facility, as defined in paragraphs (1) to (5), inclusive, of subdivision (a) of Section 1418 or in subdivision (c) of Section 1418,* prescribes or orders a medical intervention that requires that

informed consent be obtained prior to administration of the medical ~~intervention,~~ *intervention* but is unable to obtain informed consent because the physician ~~and surgeon~~ determines that the resident lacks capacity to make decisions concerning his or her health care and that there is no person with legal authority to make those decisions on behalf of the resident, the physician ~~and surgeon~~ shall inform the skilled nursing facility or intermediate care facility. *After informing the skilled nursing facility or intermediate care facility of the need for medical intervention, the unavailability of a person with legal authority to make medical treatment decisions on behalf of a resident, and the determination that the resident lacks capacity to give informed consent for the proposed interventions, the physician shall document in writing that the skilled nursing facility or intermediate care facility has been informed of these determinations. This writing shall be placed or be contained in the medical record of the resident.*

(2) The skilled nursing facility or intermediate care facility shall, orally and in writing, notify the resident of the determinations of the physician as soon as possible after the physician has informed the facility of the determinations, but no later than 48 hours. Notice provided to a resident pursuant to this section shall be in the resident's preferred language.

(b) For purposes of subdivision (a), a resident lacks capacity to make ~~a decision~~ *decisions* regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention. To make the determination regarding capacity, the physician shall interview the ~~review the patient's medical records,~~ *resident, review the resident's medical records available at the facility or readily available through electronic means,* and consult with skilled nursing *facility staff* or intermediate care facility staff, as appropriate, and family members and friends of the resident, if any have been identified.

(c) For purposes of subdivision (a), a person with legal authority to make medical treatment decisions on behalf of a ~~patient~~ *resident* is a person designated ~~under~~ *in* a valid ~~Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin.~~ *writing authorized by the Probate Code, including a durable power of attorney for health care or advance health care directive or a*

guardian, conservator, next of kin, or any other person designated by law to serve as a person with legal authority to make medical treatment decisions for the resident. To determine the existence of a person with legal authority, the physician shall interview the ~~patient,~~ *resident,* review the medical records of the ~~patient,~~ *resident,* and consult with *the* skilled nursing *facility staff* or intermediate care facility staff, as appropriate, and with family members and friends of the resident, if any have been identified. *Notwithstanding Section 4655 of the Welfare and Institutions Code, a regional center director or his or her designee shall not have the legal authority to make medical treatment decisions pursuant to subdivisions (o), (p), and (r) of this section.*

(d) The attending physician and the skilled nursing facility or intermediate care facility *defined in subdivision (a)* may initiate a medical intervention that requires informed consent pursuant to subdivision (e) in accordance with acceptable standards of ~~practice.~~ *practice and only after the notice in paragraph (2) of subdivision (a) has been provided to the resident and the resident has not initiated any judicial review of any of the physician's determinations.*

(e) ~~Where~~ *If* a resident of a skilled nursing facility or intermediate care facility has been prescribed a medical intervention by a physician ~~and surgeon~~ that requires informed consent *of the resident* and the physician has determined that the resident lacks capacity to make health care decisions and there is no person with legal authority to make those *medical intervention* decisions on behalf of the resident, the facility shall, except as provided in subdivision ~~(h),~~ *(j),* conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning, and shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a ~~patient~~ *resident* representative, in accordance with applicable federal and state requirements. *For residents eligible for and receiving regional center services under Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, the*

interdisciplinary team may include the resident's regional center service coordinator. The review shall include all of the following:

(1) A review of the physician's assessment of the resident's condition.

(2) The reason for the proposed use of the medical intervention.

(3) A ~~discussion of the desires of the patient, where~~ *consideration of the preferences of the resident, if* known. To determine the ~~desires~~ *preferences* of the resident, the interdisciplinary team shall interview the ~~patient,~~ *resident,* review the ~~patient's~~ *resident's* medical records, *including the resident's durable power of attorney and advanced health care directive,* and consult with family members or friends, if any have been identified.

(4) The type of medical intervention to be used in the resident's care, including its probable frequency and duration.

(5) The probable impact on the resident's condition, with and without the use of the *proposed* medical intervention.

(6) Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness.

(f) A ~~patient~~ *resident* representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but who has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.

(g) The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition. *Any ongoing or additional prescribed medical interventions shall continue to be overseen using the interdisciplinary team approach unless or until a person with legal authority to make decisions regarding medical treatment on behalf of the resident, as defined in subdivision (c), is identified or the physician or a court of law determines that the resident has capacity, or has regained capacity, to make decisions concerning a proposed medical intervention.*

(h) For purposes of paragraph (2) of subdivision (a), the written notice provided to the resident by the skilled nursing facility or intermediate care facility shall be developed in plain English in a manner easily understandable to residents and shall include all of the following information, and be translated into the preferred language of the resident:

(1) The medical intervention prescribed or ordered for the resident by the physician.

(2) A physician has determined that the resident is unable to understand the nature and consequences of the prescribed or ordered medical intervention, including its risks and benefits, or is unable to express a preference and therefore lacks capacity to make decisions regarding the prescribed or ordered medical intervention.

(3) No person with legal authority to make decisions regarding medical interventions on behalf of the resident has been identified, or, if identified, the person has declined to serve as a health care decisionmaker.

(4) A physician, a registered nurse with responsibility for the resident, other appropriate facility staff in disciplines as determined by the resident's needs, and, if practicable, a person representing the resident's interests shall review the determinations and prescribed medical intervention and shall review on at least a quarterly basis or upon a significant change in the resident's medical condition.

(5) Any additional prescribed interventions shall continue to be overseen using the interdisciplinary team approach unless or until a person with legal authority to make decisions regarding medical interventions on behalf of the resident, as defined in subdivision (c), is identified, or the physician or a court of law determines that the resident has capacity, or has regained capacity, to make decisions concerning a prescribed medical intervention.

(6) The resident may seek appropriate judicial relief to review any of the determinations of the physician, as set forth in this subdivision.

(7) Information on availability of advocacy assistance, including the protection and advocacy agency identified in subdivision (i) of Section 4900 of the Welfare and Institutions Code, publicly funded legal services corporations, and other publicly or privately funded advocacy organizations, and, for residents who are clients of a regional center, information about their local client's rights advocate pursuant to Section 4433 of the Welfare and Institutions Code.

(i) If a skilled nursing facility or intermediate care facility has provided written notice to a resident who is currently receiving a medical intervention under this section but for which that medical

intervention was initiated by the skilled nursing facility or intermediate care facility prior to the effective date of this subdivision, and the written notice provided to the resident includes all of the information set forth in subdivision (h), the written notice shall be considered sufficient for purposes of satisfying the requirements for written notice to a resident in paragraph (2) of subdivision (a). Nothing in this subdivision shall require the skilled nursing facility or intermediate care facility to discontinue the intervention in order for notice to be provided consistent with subdivision (h).

~~(h)~~

(j) In case of an emergency, after obtaining a ~~physician and surgeon's~~ *physician's* order *under subdivision (a),* as necessary, a skilled nursing *facility* or intermediate care facility may administer a medical intervention that requires informed consent prior to the facility convening an interdisciplinary team review. If the emergency results in the application of physical or chemical restraints, ~~the~~ *or the emergency administration of antipsychotic medication, the* interdisciplinary team shall meet ~~within one week of the emergency~~ for an evaluation of the ~~medical intervention.~~ *emergency intervention, and shall comply with the timelines outlined in paragraph (3) of subdivision (r).*

~~(i)~~

(k) Physicians ~~and surgeons~~ and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to Section 3201 of the Probate Code prior to administering a medical intervention ~~which~~ *that* requires informed consent if the requirements of this section are ~~met.~~ *met and only after the notice required in paragraph (2) of subdivision (a) has been provided to the resident.*

~~(j)~~

(l) Nothing in this section shall in any way affect the right of a resident of a skilled nursing facility or intermediate care facility for whom medical intervention has been prescribed, ordered, or administered pursuant to this section to seek appropriate judicial relief to review the decision to provide the medical intervention.

~~(k)~~

(m) No physician or other health care provider, *including the independent physician, as described in subdivision (r),* whose action under this section is in accordance with reasonable medical

standards, is subject to administrative sanction if the physician or health care provider believes in good faith that the action is consistent with this section and the desires of the resident, or if unknown, the best interests of the resident. *Notwithstanding any other law, there shall not be monetary liability on the part of, and there shall not be a cause of action for damages arising against, an independent physician for any act performed during the review of a medical intervention for antipsychotic medication prescribed or ordered for a resident, as provided in subdivision (r), if the independent physician acts without malice, has made a reasonable effort to obtain the facts of the matter, and approves or disapproves the medical intervention for antipsychotic medications as warranted by the facts.*

~~(l)~~

(n) The determinations required to be made pursuant to subdivisions (a), (e), and (g), and the basis for those ~~determinations~~ *determinations,* shall be documented in the ~~patient's~~ *resident's* medical record and shall be made available to the ~~patient's~~ *resident's* representative for review. *A copy of the written notice to the resident of the determinations, as set forth in subdivision (h), shall be retained in the resident's medical record, along with written acknowledgment by the resident of his or her receipt of the written notice if provided, or documentation by the skilled nursing facility or intermediate care facility that the resident has received the notice. The written notice and acknowledgment of the resident's receipt of the written notice, and the documentation in the resident's medical record of the determinations made pursuant to subdivisions (a), (e), and (g), shall be made available to the resident or the resident's representative for review or copying, upon request.*

(o) Nothing in this section shall authorize a skilled nursing facility, intermediate care facility, or the physician to make decisions regarding the withholding or withdrawal of potentially life-sustaining treatment for a resident, except to the extent consistent with the resident's individual health care instructions, if any, and other wishes, to the extent known; provided, however, that a physician or facility may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the

physician or facility pursuant to Sections 4735 and 4736 of the Probate Code.

(p) Notwithstanding subdivision (o), the procedures in subdivision (e) may be used to provide or initiate hospice or comfort care to a resident unless inconsistent with the resident's individual health care instructions, if any, and other expressed wishes, to the extent known, or if that care would not be in the resident's best interests.

(q) The skilled nursing facility or intermediate care facility shall develop, adopt, and implement policies and procedures for the administration of an antipsychotic medication to a resident. The policies and procedures shall include procedures for the emergency administration of an antipsychotic medication to a resident to the extent allowed by this section and shall be developed prior to the emergency administration of an antipsychotic medication.

(r) The policies and procedures required pursuant to subdivision (q) that are adopted by the facility regarding the administration of antipsychotic medication shall include all of the following:

(1) Prior to the administration of an antipsychotic medication to a resident, the skilled nursing facility or intermediate care facility shall convene a review at the facility before an independent physician in order to review the appropriateness of the proposed medical intervention. The review shall be provided at no cost to the resident.

(2) The review by the independent physician shall be held at the facility or by videoconferencing technology no earlier than seven days after notice is provided to the resident as required by paragraph (2) of subdivision (a).

(3) If an antipsychotic medication has been administered for an emergency purpose pursuant to subdivision (j), the skilled nursing facility or the intermediate care facility shall, within 14 days of the initial administration of the antipsychotic medication to the resident, do all of the following:

(A) Require the interdisciplinary team to meet and evaluate the medical intervention, and determine whether the team has found the intervention to be appropriate.

(B) Provide the resident with a review before an independent physician, pursuant to this subdivision.

(C) Require the independent physician to provide a written decision pursuant to paragraph (10).

(D) Provide the independent physician's decision to the resident, the resident's advocate, and the resident's representative, if one has been identified in subdivision (e), pursuant to paragraph (11).

(4) The independent physician shall be licensed by the state and shall be retained by the facility at no charge to the patient. The independent physician shall meet the following requirements:

(A) Be knowledgeable in the clinical indications, use, administration, risks, and benefits of antipsychotic medications.

(B) Not currently provide or have previously provided any health care services to the resident.

(C) Not currently serve or have previously served on any committee to review either the health care services or the policies and procedures of the skilled nursing facility or intermediate care facility.

(D) Not be employed by the licensee, skilled nursing facility, intermediate care facility, or any of the licensee's health care facilities.

(E) Not have any ownership interest in the skilled nursing facility or intermediate care facility or in any of the licensee's business entities or health care facilities.

(F) Not be financially compensated by the licensee or the facility, other than to provide the review regarding the proposed medical intervention, as contemplated in this subdivision.

(5) (A) A resident may retain an advocate, of his or her own choice, to represent his or her interests at the review before the independent physician. If the resident does not retain an advocate, the skilled nursing or intermediate care facility shall provide, at no expense to the resident, an advocate to assist the resident at the review. Any advocate supplied by the facility shall have at least the following minimum qualifications:

(i) Experience in patient or client advocacy in a medical setting.

(ii) Experience in capacity, guardianship, or conservatorship proceedings.

(iii) Knowledge of disability rights, patients' rights, or mental health law.

(iv) Close proximity or willingness to travel to the skilled nursing facilities or intermediate care facilities where the review will take place.

(B) An advocate provided by the facility shall, under contract with the facility, provide advocacy services to any resident for the

sole purpose of assistance and representation at reviews contemplated in this subdivision. An advocate provided by the facility shall not be employed by or otherwise contract with the licensee, skilled nursing facility, intermediate care facility, or any of the licensee's business entities or health care facilities. An advocate provided by the facility to a resident shall not have any ownership interest in the facility or in any of the licensee's business entities or health care facilities. The advocate shall not be financially compensated by the licensee or facility, other than as allowed in this subdivision.

(6) Written notice of the time, date, and location of the review shall be provided by the facility to the resident, in the resident's preferred language, and the resident's advocate and a representative, if one has been identified, as described in subdivision (e), no later than five days before the review. The notice shall include all of the following:

(A) The right to review or have copies of the resident's medical records available at the facility, or readily available through electronic means, in advance of the review.

(B) The procedures to be followed during the review, including the right to an interpreter if the resident's preferred language is not English.

(C) The opportunity to rebut any evidence presented by the physician or interdisciplinary team regarding the appropriateness of the proposed administration of an antipsychotic medication.

(D) The right of the resident, the resident's advocate or representative, and any witnesses to attend the review.

(7) Within 24 hours of a request by the resident, the advocate, or a representative, if one has been identified, as described in subdivision (e), the skilled nursing facility or intermediate care facility shall provide access to, and, if requested, copies of, the resident's medical records available at the facility, or readily available through electronic means.

(8) At the independent physician review, the resident, with the assistance of the resident's advocate and a representative, if one has been identified, the physician who ordered the proposed administration of an antipsychotic medication, and a representative of the interdisciplinary team shall be given a reasonable and equal opportunity to present information concerning the appropriateness of the proposed administration of an antipsychotic medication and

an equal and reasonable opportunity to question the physician who ordered the proposed antipsychotic medical intervention, members of the interdisciplinary team, and any witnesses.

(9) Except as provided in paragraph (3) of subdivision (r), within seven days of the conclusion of a review, the independent physician shall make a decision either approving or disapproving the proposed administration of an antipsychotic medication. The decision shall be in writing and shall include the basis for the decision and the evidence relied upon.

(10) (A) A written copy of the independent physician's decision shall be provided to the resident, in the resident's preferred language, and the resident's advocate and representative, if one has been identified, as described in subdivision (e), by the skilled nursing facility or intermediate care facility. The notice shall also advise the resident that the resident has a right to seek judicial review of the independent physician's decision to approve or disapprove any prescribed or ordered medical intervention requiring the administration of antipsychotic medication and information on availability of advocacy assistance, including the protection and advocacy agency identified in subdivision (i) of Section 4900 of the Welfare and Institutions Code, publicly funded legal services corporations, and other publicly or privately funded advocacy organizations. Written notice provided to a resident pursuant to this section shall be translated to the preferred language of the resident.

(B) Except in the case of emergency administration of antipsychotic medication to a resident, the facility shall not administer an antipsychotic medication following the independent review until the resident, the resident's advocate, and the resident's representative receive written copies of the independent physician's decision.

(11) The independent review of administration of any prescribed or ordered antipsychotic medication to a resident, pursuant to this section, shall only be required if the antipsychotic medication proposed to be administered is either prescribed for the first time while the resident is a patient of the skilled nursing or intermediate care facility or has not previously been subject to a review and hearing by an independent physician, as provided for in this subdivision, but for which the antipsychotic medication was prescribed pursuant to subdivision (a).

(12) Every two years from the administration of an antipsychotic medication, the resident and the resident's representative, if one has been identified in subdivision (e), shall be notified in writing of the intent to continue administration of an antipsychotic medication for the resident's medical condition, and the resident's right to request a review by an independent physician pursuant to this section. Notice provided to a resident pursuant to this section shall be developed in plain English in a manner easily understandable to residents and be in the resident's primary language.

(s) "Antipsychotic medication" means a medication approved by the United States Food and Drug Administration for the treatment of psychosis.

(t) Nothing in subdivision (r) shall be construed to alter or impact the rights of residents pertaining to capacity hearings required by the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), as set forth in Article 7 (commencing with Section 5325) of that act.

(u) All records of the review by the independent physician shall be retained in the resident's medical record, and the department shall have access to, and may inspect, these records.

~~SECTION 1. Section 1366.22 of the Health and Safety Code is amended to read:~~

~~1366.22. The continuation coverage requirements of this article do not apply to the following individuals:~~

~~(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.~~

~~(b) Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group conversion option under any group benefit~~

~~plan shall not be considered as an arrangement under which an individual is or becomes covered.~~

~~(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).~~

~~(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act (42 U.S.C. Sec. 300bb-1 et seq.).~~

~~(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 1366.24 or subdivision (i) of Section 1366.25 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.~~

~~(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract.~~

~~SEC. 2. Section 1366.24 of the Health and Safety Code is amended to read:~~

~~1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.~~

~~(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days~~

~~will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article shall request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment shall equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.~~

~~(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.~~

~~(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.~~

~~(e) Every plan disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.~~

~~(f) A disclosure issued, amended, or renewed on or after July 1, 2016, for a group benefit plan subject to this article shall include the following notice:~~

~~–~~

~~"In addition to your coverage continuation options, you may be eligible for the following:~~

~~1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower~~

~~out-of-pocket costs. Your family members may also qualify for coverage through Covered California.~~

~~2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.~~

~~3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.~~

~~Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal at anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."~~

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~~(g) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.~~

~~(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.~~

~~SEC. 3. Section 1366.24 is added to the Health and Safety Code, to read:~~

~~1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.~~

~~(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1),~~

~~(3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay any required premiums and all~~

~~premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.~~

~~(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.~~

~~(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.~~

~~(e) Every plan disclosure form issued, amended, or renewed on or after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.~~

~~(f) Every disclosure issued, amended, or renewed on or after the operative date of this section for a group benefit plan subject to this article shall include the following notice:~~

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~~"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual~~

health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

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(g) A disclosure issued, amended, or renewed on or after July 1, 2016, for a group benefit plan subject to this article shall include the following notice:

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"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

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(h) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 4. Section 1366.25 of the Health and Safety Code is amended to read:

~~1366.25. (a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).~~

~~(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.~~

~~Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).~~

~~(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified~~

~~beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.~~

~~(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.~~

~~(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.~~

~~(f) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is~~

~~terminated because the group contract between the plan and the employer is being terminated.~~

~~(g) (1) A health care service plan shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:~~

~~(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if a health care service plan is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.~~

~~(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.~~

~~(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.~~

~~(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.~~

~~(E) The duration of premium assistance available under ARRA.~~

~~(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.~~

~~(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision~~

~~has the right to withdraw that rejection and elect continuation coverage with the premium assistance.~~

~~(H) A statement that reads as follows:~~

~~"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of health plan] at [insert appropriate telephone number]."~~

~~(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the plan receives notice of the qualifying event.~~

~~(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).~~

~~(4) Nothing in this section shall be construed to require a health care service plan to provide the plan's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require a health care service plan to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.~~

~~(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (i) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:~~

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"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

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(i) (1) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following,

~~at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:~~

~~(A) The date of the qualifying event.~~

~~(B) The first day of the month following the election.~~

~~(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (k). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 1366.27, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.~~

~~(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election opportunity under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.~~

~~(j) A health care service plan shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.~~

~~(k) A health care service plan, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:~~

~~(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:~~

~~(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy~~

~~offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.~~

~~(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.~~

~~(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.~~

~~(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.~~

~~(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The plan shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.~~

~~(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (i) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided~~

~~the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(5) If an individual does not qualify for either a special election period or the premium assistance under ARRA, the health care service plan shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.~~

~~(6) A health care service plan shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. A plan may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the plan's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.~~

~~(*l*) For purposes of implementing federal premium assistance for continuation coverage, the department may designate a model notice or notices that may be used by health care service plans. Use of the model notice or notices shall not require prior approval of the department. Any model notice or notices designated by the department for purposes of this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).~~

~~(m) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.~~

~~(n) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.~~

~~(o) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under~~

~~ARRA, pursuant to subdivision (i), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.~~

~~(p) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, a health care service plan may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.~~

~~(2) A health care service plan that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the plan receives the qualified beneficiary's election notice pursuant to subdivision (i). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the health care service plan written verification as to whether the covered employee's employment was involuntarily terminated.~~

~~(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the health care service plan a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.~~

~~(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either~~

provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

(q) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.

(r) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 5. Section 1366.25 is added to the Health and Safety Code, to read:

1366.25. (a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).

(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the

~~end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.~~

~~Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).~~

~~(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.~~

~~(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require~~

~~an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.~~

~~(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.~~

~~(f) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the plan and the employer is being terminated.~~

~~(g) (1) A health care service plan shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:~~

~~(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if a health care service plan is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount~~

~~and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.~~

~~(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.~~

~~(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.~~

~~(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.~~

~~(E) The duration of premium assistance available under ARRA.~~

~~(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.~~

~~(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.~~

~~(H) A statement that reads as follows:~~

~~"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of health plan] at [insert appropriate telephone number]."~~

~~(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the plan receives notice of the qualifying event.~~

~~(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision~~

~~shall be provided within the period of time specified in subdivision (e).~~

~~(4) Nothing in this section shall be construed to require a health care service plan to provide the plan's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require a health care service plan to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.~~

~~(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (k) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after the operative date of this section shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:~~

~~–~~

~~"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."~~

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~~(i) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:~~

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~~"In addition to your coverage continuation options, you may be eligible for the following:~~

~~1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.~~

~~2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.~~

~~3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.~~

~~Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."~~

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~~(j) (1) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).~~

~~(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.~~

~~(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.~~

~~(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:~~

~~(A) The date of the qualifying event.~~

~~(B) The first day of the month following the election.~~

~~(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (*l*). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 1366.27, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.~~

~~(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election opportunity under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.~~

~~(k) A health care service plan shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.~~

~~(*l*) A health care service plan, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:~~

~~(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:~~

~~(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.~~

~~(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.~~

~~(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.~~

~~(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.~~

~~(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The plan shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.~~

~~(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (j) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that~~

~~qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(5) If an individual does not qualify for either a special election period or the premium assistance under ARRA, the health care service plan shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.~~

~~(6) A health care service plan shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. A plan may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the plan's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.~~

~~(m) For purposes of implementing federal premium assistance for continuation coverage, the department may designate a model notice or notices that may be used by health care service plans. Use of the model notice or notices shall not require prior approval of the department. Any model notice or notices designated by the department for purposes of this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).~~

~~(n) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.~~

~~(o) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.~~

~~(p) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (j), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the~~

~~Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.~~

~~(q) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, a health care service plan may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.~~

~~(2) A health care service plan that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the plan receives the qualified beneficiary's election notice pursuant to subdivision (j). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the health care service plan written verification as to whether the covered employee's employment was involuntarily terminated.~~

~~(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the health care service plan a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.~~

~~(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a~~

~~denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.~~

~~(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.~~

~~(r) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.~~

~~(s) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.~~

~~(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.~~

~~SEC. 6. Section 24100 of the Health and Safety Code is amended to read:~~

~~24100. (a) For purposes of this section, the following definitions apply:~~

~~(1) "ARRA" means Title III of Division B of the federal American Recovery and Reinvestment Act of 2009 or any amendment to that federal law extending federal premium assistance to qualified beneficiaries, as defined in Section 1366.21 of this code or Section 10128.51 of the Insurance Code.~~

~~(2) "Employer" means an employer as defined in Section 1366.21 of this code or an employer as defined in Section 10128.51 of the Insurance Code.~~

~~(b) An employer shall provide the information described in subparagraph (B) of paragraph (1) of subdivision (k) of Section 1366.25 of this code or subparagraph (B) of paragraph (1) of subdivision (k) of Section 10128.55 of the Insurance Code, as applicable, with respect to any employee whose employment is terminated on or after March 2, 2010, and who was enrolled at any time in a health care service plan or health insurance policy offered by the employer on or after September 1, 2008. This information~~

~~shall be provided to the requesting health care service plan or health insurer within 14 days of receipt of the notification described in paragraph (1) of subdivision (k) of Section 1366.25 of this code or paragraph (1) of subdivision (k) of Section 10128.55 of the Insurance Code. The employer shall continue to provide the information to the health care service plan or health insurer within 14 days after the end of each month for any employee whose employment is terminated in the prior month until the last date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA.~~

~~SEC. 7. Section 10128.52 of the Insurance Code is amended to read:~~

~~10128.52. The continuation coverage requirements of this article do not apply to the following individuals:~~

~~(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.~~

~~(b) Individuals who have other hospital, medical, or surgical coverage, or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 10198.6 and 10198.7. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.~~

~~(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).~~

~~(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act (42 U.S.C. Sec. 300bb-1 et seq.).~~

~~(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 10128.54 or subdivision (i) of Section~~

~~10128.55 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.~~

~~(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 10128.55 and Section 10128.57, in accordance with the terms and conditions of the policy or contract, or fail to satisfy other terms and conditions of the policy or contract.~~

~~SEC. 8. Section 10128.54 of the Insurance Code is amended to read:~~

~~10128.54. (a) Every insurer's evidence of coverage for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.~~

~~(b) This disclosure shall state that all insureds who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 10128.51, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the insurer, or the employer if the employer contracts to perform the administrative services as provided for in Section 10128.55, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 10128.51 within 60 days of the date of the qualifying event. This disclosure shall inform insureds that failure to make the notification to the insurer, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article shall request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of (1) the date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured

~~was sent notice pursuant to subdivision (e) of Section 10128.55 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the disability insurer, in accordance with the terms and conditions of the policy or contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 10128.55, the amount of the required premium payment, as set forth in Section 10128.56. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the employer has contracted with the insurer to perform the administrative services pursuant to subdivision (d) of Section 10128.55, within 45 days of the date the qualified beneficiary provided written notice to the insurer or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment shall equal an amount sufficient to pay all required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.~~

~~(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to Section 10128.57 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.~~

~~(d) Prior to August 1, 1998, every insurer shall provide to all covered employees of employers subject to this article written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this~~

~~article a new or amended evidence of coverage that includes the disclosures required by this section. Any insurer that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits, and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchases of benefits.~~

~~(e) Every disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an insured may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the evidence of coverage.~~

~~(f) A disclosure issued, amended, or renewed on or after July 1, 2016, for a group benefit plan subject to this article shall include the following notice:~~

~~–~~

~~"In addition to your coverage continuation options, you may be eligible for the following:~~

~~1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.~~

~~2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.~~

~~3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.~~

~~Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal at anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."~~

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~~(g) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this~~

~~section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.~~

~~(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.~~

~~SEC. 9. Section 10128.54 is added to the Insurance Code, to read:~~

~~10128.54. (a) Every insurer's evidence of coverage for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.~~

~~(b) This disclosure shall state that all insureds who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 10128.51, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the insurer, or the employer if the employer contracts to perform the administrative services as provided for in Section 10128.55, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 10128.51 within 60 days of the date of the qualifying event. This disclosure shall inform insureds that failure to make the notification to the insurer, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of (1) the date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice pursuant to subdivision (e) of Section 10128.55~~

~~of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the disability insurer, in accordance with the terms and conditions of the policy or contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 10128.55, the amount of the required premium payment, as set forth in Section 10128.56. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the employer has contracted with the insurer to perform the administrative services pursuant to subdivision (d) of Section 10128.55, within 45 days of the date the qualified beneficiary provided written notice to the insurer or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay all required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.~~

~~(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to Section 10128.57 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.~~

~~(d) Prior to August 1, 1998, every insurer shall provide to all covered employees of employers subject to this article written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this article a new or amended evidence of coverage that includes the~~

~~disclosures required by this section. Any insurer that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits, and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchases of benefits.~~

~~(e) Every disclosure form issued, amended, or renewed on or after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an insured may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the evidence of coverage.~~

~~(f) Every disclosure issued, amended, or renewed on or after the operative date of this section for a group benefit plan subject to this article shall include the following notice:~~

~~–~~

~~"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."~~

~~–~~

~~(g) A disclosure issued, amended, or renewed on or after July 1, 2016, for a group benefit plan subject to this article shall include the following notice:~~

~~–~~

~~"In addition to your coverage continuation options, you may be eligible for the following:~~

~~1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.~~

~~2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.~~

~~3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.~~

Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

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(h) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 10. Section 10128.55 of the Insurance Code is amended to read:

10128.55. (a) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the insurer in writing of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 10128.51, within 30 days of the qualifying event. The group contract shall also require the employer to notify the insurer, in writing, within 30 days of the date when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).

(b) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 10128.57, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group

~~benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.~~

~~Every disability insurer shall provide to the employer replacing a group benefit plan policy issued by the insurer, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the insurer reasonably required to administer the notification requirements of this subdivision and subdivision (c).~~

~~(c) Notwithstanding subdivision (a), the group benefit plan contract between the insurer and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 10128.54 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the group benefit plan and those qualified beneficiaries who have been notified, pursuant to Section 10128.54 of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or, disability insurer currently providing continuation coverage to the qualified beneficiary. The successor insurer shall not be obligated to provide this information to qualified beneficiaries if the employer or prior insurer or health care service plan fails to comply with this section.~~

~~(d) A disability insurer may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the insurer. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit an insurer to require an employer to perform the administrative obligations of the insurer as required by this article as a condition of the issuance or renewal of coverage.~~

~~(e) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this~~

~~section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 10128.54 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.~~

~~(f) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 10128.57, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the insurer and the employer is being terminated.~~

~~(g) (1) An insurer shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:~~

~~(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if an insurer is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.~~

~~(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall~~

~~not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.~~

~~(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.~~

~~(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.~~

~~(E) The duration of premium assistance available under ARRA.~~

~~(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.~~

~~(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.~~

~~(H) A statement that reads as follows:~~

~~"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of insurer] at [insert appropriate telephone number]."~~

~~(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the insurer receives notice of the qualifying event.~~

~~(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).~~

~~(4) Nothing in this section shall be construed to require an insurer to provide the insurer's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require an insurer to amend its existing~~

~~evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.~~

~~(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (i) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if an insurer previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:~~

~~–~~

~~"In addition to your coverage continuation options, you may be eligible for the following:~~

~~1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.~~

~~2. Coverage through Medi-Cal. Depending on your income, you may qualify for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.~~

~~3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.~~

~~Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."~~

~~–~~

~~(i) (1) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect~~

~~continuation coverage no later than 60 days after the date of the notice required by subdivision (g).~~

~~(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (e) of Section 10198.7 or subdivision (c) of Section 10708.~~

~~(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.~~

~~(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:~~

~~(A) The date of the qualifying event.~~

~~(B) The first day of the month following the election.~~

~~(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (k). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 10128.57, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.~~

~~(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election period under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.~~

~~(j) An insurer shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.~~

~~(k) A health insurer, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:~~

~~(1) The insurer shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the insurer for a group benefit plan subject to this article. The notice shall do all of the following:~~

~~(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.~~

~~(B) Ask the employer to provide the insurer with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.~~

~~(C) Provide employers with a format and instructions for submitting the information to the insurer, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.~~

~~(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the insurer shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.~~

~~(3) If an individual contacts his or her health insurer and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the insurer shall provide the individual with the notice required under paragraph (17) of~~

~~subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the insurer receives or received information from the individual's previous employer regarding that individual pursuant to Section 24100 of the Health and Safety Code. The insurer shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The insurer shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.~~

~~(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (i) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health insurer previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(5) If an individual does not qualify for either a special election period or the subsidy under ARRA, the insurer shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.~~

~~(6) A health insurer shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. An insurer may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the insurer's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.~~

~~(*l*) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.~~

~~(m) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.~~

~~(n) An insurer that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (i), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.~~

~~(o) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, an insurer may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.~~

~~(2) An insurer that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the insurer receives the qualified beneficiary's election notice pursuant to subdivision (i). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the insurer written verification as to whether the covered employee's employment was involuntarily terminated.~~

~~(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the insurer a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the insurer to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the insurer makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.~~

~~(4) If an insurer requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the insurer receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the insurer shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.~~

~~(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.~~

~~(p) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.~~

~~(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.~~

~~SEC. 11. Section 10128.55 is added to the Insurance Code, to read:~~

~~10128.55. (a) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the insurer in writing of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 10128.51, within 30 days of the qualifying event. The group contract shall also require the employer to notify the insurer, in writing, within 30 days of the date when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).~~

~~(b) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage,~~

~~whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 10128.57, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.~~

~~Every disability insurer shall provide to the employer replacing a group benefit plan policy issued by the insurer, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the insurer reasonably required to administer the notification requirements of this subdivision and subdivision (c).~~

~~(c) Notwithstanding subdivision (a), the group benefit plan contract between the insurer and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 10128.54 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the group benefit plan and those qualified beneficiaries who have been notified, pursuant to Section 10128.54 of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or, disability insurer currently providing continuation coverage to the qualified beneficiary. The successor insurer shall not be obligated to provide this information to qualified beneficiaries if the employer or prior insurer or health care service plan fails to comply with this section.~~

~~(d) A disability insurer may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the insurer. Except for the~~

~~requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit an insurer to require an employer to perform the administrative obligations of the insurer as required by this article as a condition of the issuance or renewal of coverage.~~

~~(e) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 10128.54 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.~~

~~(f) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 10128.57, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the insurer and the employer is being terminated.~~

~~(g) (1) An insurer shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:~~

~~(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if an insurer is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an~~

~~opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.~~

~~(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.~~

~~(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.~~

~~(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.~~

~~(E) The duration of premium assistance available under ARRA.~~

~~(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.~~

~~(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.~~

~~(H) A statement that reads as follows:~~

~~"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of insurer] at [insert appropriate telephone number]."~~

~~(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the insurer receives notice of the qualifying event.~~

~~(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision~~

~~shall be provided within the period of time specified in subdivision (e).~~

~~(4) Nothing in this section shall be construed to require an insurer to provide the insurer's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require an insurer to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.~~

~~(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (h) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if an insurer previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after the operative date of this section shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:~~

~~–~~

~~"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."~~

~~–~~

~~(i) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:~~

~~–~~

~~"In addition to your coverage continuation options, you may be eligible for the following:~~

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify

for low or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California, although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

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(j) (1) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (e) of Section 10198.7 or subdivision (e) of Section 10708.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

~~(A) The date of the qualifying event.~~

~~(B) The first day of the month following the election.~~

~~(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (*l*). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 10128.57, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.~~

~~(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election period under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.~~

~~(k) An insurer shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.~~

~~(*l*) A health insurer, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:~~

~~(1) The insurer shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the insurer for a group benefit plan subject to this article. The notice shall do all of the following:~~

~~(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.~~

~~(B) Ask the employer to provide the insurer with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.~~

~~(C) Provide employers with a format and instructions for submitting the information to the insurer, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.~~

~~(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the insurer shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.~~

~~(3) If an individual contacts his or her health insurer and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the insurer shall provide the individual with the notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the insurer receives or received information from the individual's previous employer regarding that individual pursuant to Section 24100 of the Health and Safety Code. The insurer shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The insurer shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.~~

~~(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (j) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health insurer previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.~~

~~(5) If an individual does not qualify for either a special election period or the subsidy under ARRA, the insurer shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.~~

~~(6) A health insurer shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. An insurer may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the insurer's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.~~

~~(m) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.~~

~~(n) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.~~

~~(o) An insurer that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (j), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.~~

~~(p) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, an insurer may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.~~

~~(2) An insurer that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do~~

~~so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the insurer receives the qualified beneficiary's election notice pursuant to subdivision (h). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the insurer written verification as to whether the covered employee's employment was involuntarily terminated.~~

~~(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the insurer a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the insurer to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the insurer makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.~~

~~(4) If an insurer requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the insurer receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the insurer shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.~~

~~(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.~~

~~(q) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.~~

~~(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education~~

~~Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.~~

~~SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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